Innovation and Improvement in Maternity Services

Researched and written by
Hannah Jameson, IPA
Foreword

Ever since the inception of the NHS in 1948, it has always been incumbent on maternity services to pioneer innovative care of the highest standard and quality for women and families. Indeed midwives have a long tradition of promoting new concepts long before similar policies were more widely adopted in the NHS – from women-centred care, to choice of location and type of treatment.

Whilst it has always been right in principle that maternity services innovate, the current pressures that are impacting on the NHS provide additional impetus to do so. Factors such as an ageing population, the growth of lifestyle diseases such as diabetes and obesity and growing costs associated with technological advances when combined with the current economic downturn, mean that the NHS has to be able to deliver more productive and better quality care while operating within very constrained budgets. In other words the NHS has to do more with less and that is why the NHS in England has been set the challenge of achieving £20 billion in efficiency savings by 2015.

This guide, which has been produced in association with the Involvement and Participation Association (IPA), therefore provides some timely examples of ways in which maternity services are innovating and making improvements to the care that women and families receive, and at the same time doing so within budget or even generating efficiency savings. The IPA has selected case studies that are all quite different in terms of scale, objectives and methodologies but what they all demonstrate is that it is possible to develop new and more effective ways of working and in doing so, improve maternity outcomes and women’s experience of care.

What all of these schemes demonstrate, in their diverse ways, is the importance of underpinning change programmes with sound organising principles, which in the context of maternity services means:

- Support from leaders at all levels of the organisation, from teams and wards to Trust Boards.
- Effective team working and the ability to learn from each other.
- Integration of services across acute and community settings.
- Care that is accessible for all women but which is also tailored to their individual needs and circumstances.

Whether you are a midwife, a workplace representative, a manager, a commissioner or you are simply interested in maternity services, I hope that this guide provides you with the inspiration – and some practical suggestions – as to how you can improve your local maternity services.

Professor Cathy Warwick CBE
Chief Executive, Royal College of Midwives
Innovation and Improvement in Maternity Services

Contents

Executive Summary 1

Introduction 6

Case Studies
  1. The South Central Strategic Health Authority maternity network 10
  2. Productive Maternity at Nottingham 15
  3. Maternity Support Worker Apprenticeships at Basildon 20
  4. Modernising maternity at East Cheshire NHS trust 24

Conclusions 28
Innovation and Improvement in Maternity Services

Executive Summary

Reductions in public sector spending, rising costs, demographic change, and increased public expectations are forcing public services to find new ways of working and hence to focus on innovation.

What is Innovation?

The NHS Institute for Innovation and Improvement describes innovation as being “about doing things differently or doing different things to achieve large gains in performance”. Public sector innovation must be assessed on a range of social as well as economic value indicators.

Drivers for innovation may include political pushes, the capacity and desires of the workforce, financial and non-financial support, technology, and the presence or involvement of third and private sector organisations.

The level of autonomy individuals and organisations have can affect their ability to develop and test new ideas, and to implement change. Clearly the accountability and ownership structures of the public sector affect levels of autonomy.

Human capital is also a key factor in innovation, and the skills necessary for innovation, such as creativity, team working and cognitive skills, are becoming increasingly important.

Innovation in the NHS

Work is only just beginning to measure innovation capability and activity in the NHS, and its impact on performance, but the perception has always been that the structures and cultures of the NHS work to inhibit innovation.

However, innovation does take place in the NHS, and government policy has tried to make it more of a priority through, for example, the QIPP agenda. The NHS Institute finds that the innovation that takes place in the NHS is likely to be service or process innovation. The biggest impact of NHS innovation is thought to be efficiency, and in the current public spending climate, this continues to be a priority.

Research finds that public sector innovation is often initiated by frontline staff and middle managers, although the prevailing culture and systems in place often do not work to support innovation. Other barriers are that staff do not feel that innovation is part of their day to day job and change fatigue, particularly if change initiatives are ‘owned’ and led from the top of the organisation.

Innovation and improvement in maternity services

Historically, the principal driver of innovation and improvement in maternity services has been safety. A more recent driver of change has been the desire to increase choice for women through pregnancy, birth and in postnatal care.
In addition, quality and value for money have also been important. For example there has been widespread support to increase the normal birth rate, in the belief that normal birth offers good outcomes for women and babies and is a more effective use of resources.

Innovation in maternity services is also affected by structural factors. Rises in demand and an increase in births with complicating factors, have outstripped increases in workforce size and trusts have had to increase productivity significantly to provide a good level of service with fewer resources.

**About the report**

This research was conducted to find out what drives and enables innovation and improvement in maternity service. Where innovation is taking place, why it has happened, and what factors have enabled change?

The financial pressures facing the NHS and the structural reorganisation associated with the Health and Social Care Act will affect the nature of innovation and improvement. Two of these case studies show the role that SHAs can play in driving innovation and providing the necessary information and resources. SHAs are to be abolished, but there may be important lessons that can be drawn for future regional networks. The impact of the reforms on the workforce and workforce morale are also critical. The case studies show the role that midwives can play in designing and leading service improvement if they have the time, support and resources.

**Case Studies**

**The South Central Strategic Health Authority maternity network**

This SHA covers a population of 4 million. There are approximately 50,000 births per year, largely delivered at the region’s 11 hospitals, and recent years have seen an increasing birth rate.

**The challenge**

The SHA identified the need for £12 million in savings from the maternity budget over the next three years. At the same time the SHA wanted to improve commissioning, productivity, quality and safety and reduce unnecessary variation of maternity services across the region.

**The solution**

Strengthening of the existing maternity network, bringing together commissioners and providers, to act as a more effective driver of performance improvement.

**Lessons learned**

- Networks - can be a powerful tool
- Resources - networks need to be properly resourced to deliver greater value
- Leadership - is vital in making sure networks deliver tangible outcomes
- Information – networks and SHAs have access to the information necessary for performance management and innovation
Productive maternity at Nottingham University Hospitals Trust

The trust delivers approximately 10,500 babies per year and employs 350 midwives and 74 maternity support workers in 2 consultant led units, a stand alongside midwife led unit and the community midwifery service for the area.

The challenge

Data from patients, employees and CQC reports highlighted the need for improvement. Changes in staffing levels had made some ways of working unsustainable and there was a need to look at the maternity service as a whole, to review practice and procedure and identify improvements that would benefit women and staff and improve value for money.

The solution

Productive Maternity was launched in January 2011 and a project lead post was created to coordinate the work. The project has a steering-group made up of senior managers and clinical leads. The objectives of the project are:

- To have staff who are proud of where they work, what they do and how they do it
- To have clear processes which will enable staff to deliver consistent care with excellence
- To have a service which responds to feedback from women staff and other service-users
- To have a culture of continuous assessment and improvement

In the first area for review, the antenatal clinic, a process mapping exercise, engaging as many staff as possible, led to an understanding of how the services currently worked. Staff identified a number of areas of improvement leading to an initial day’s trial of the changes, followed by the scheduling of a longer trial and evaluation which will inform the decision whether the changes should be implemented permanently.

Lessons learned

- Infrastructure and processes – a clear set of processes through which innovation and improvement can take place is important, but lack of staff time can limit their involvement.
- Skills and training – project management training enabled project delivery.
- Support – senior managers with decision-making ability offered advice and were able to remove obstacles to change.
- Clinical leadership – the project is led by two midwives which has encouraged staff participation.
Maternity Support Worker Apprenticeships at Basildon and Thurrock University Hospitals
NHS Foundation Trust

The maternity service delivers between 4,100 and 4,300 babies per year at Basildon hospital. It has 146 midwives and 36 maternity support workers.

The challenge

The SHA wanted to achieve the midwife to birth ratio of 1 midwife for every 30 births. To achieve this it was estimated that a further 600 midwives would be needed across the region. The SHA also set a target for maternity units to achieve a 90/10 ratio in the maternity workforce, between midwives and support workers.

The solution

Qualified midwife support workers (MSWs) can make up 10 per cent of the midwife numbers in the midwife to birth ratio and enable maternity units to focus midwife resources where their expertise is critical, such as caring for women in labour. In 2009 the SHA offered the opportunity to develop a bespoke MSW apprenticeship course which the head of midwifery at Basildon took up.

The first students started the two year course in November 2010. The course is accredited by City and Guilds and now comprises three modules - Key skills: level two literacy & numeracy; technical certificate; level three diploma in maternity and paediatric support. In 2011 the SHA confirmed funding to run the course again.

Lessons learned

- Regional leadership – the SHA played a key role in providing funding and support
- Autonomy – on workforce matters meant that Basildon maternity unit could act quickly to take up the funding opportunity for MSW apprenticeships
- Workforce support – for expanding MSW roles was gained by consulting midwives on what resources management could provide to help them to release time to care.

1 The RCM recommends a ratio of 1 whole-time equivalent (wte) midwife for every 28 births for hospital births and 1 wte midwife for every 35 births for births at home or in midwife-led units.
Modernising maternity at East Cheshire NHS Trust

The maternity service covers a large geographical area, delivering approximately 2000 babies per year in one consultant led maternity unit in Macclesfield.

The challenge

In 2003 the service was organised into 8 teams which whilst creating more flexibility also created variation across the service as teams adopted their own ways of working.

The solution

Three new team leader posts were created, each overseeing up to three teams. These new roles were intended to create more capacity to lead service improvement and to increase coordination between the teams.

Lessons learned

- Leadership – creating leadership capacity at the right level and with a mandate to improve services enabled change to take place
- Patient feedback – can be a powerful tool in service redesign and helped leaders build a case for change
- Change – if well managed can help build support and momentum for further change, leading to a culture of continuous improvement.

Conclusions

Maternity units are reshaping their services to cope with rising demand and restricted resources. Those leading change or looking to innovate are doing so in order to improve quality, safety and value for money.

In pursuing improvement, leaders are trying to build long lasting capacity, cultures and structures for innovation. Helping frontline staff to see innovation and improvement as a core part of their role, and giving them the tools to make change, will be important in creating innovation intensity.

Improvements that are designed and led by midwives can have several advantages, however, midwives do not necessarily have the skills to lead innovation and improvement, and so it can be necessary to invest in leadership and management skills.

Building relationships between different professional groups is a reoccurring theme in the studies. By creating well resourced networks which connect people together, new practice and knowledge can be readily shared.

Several of the studies show the importance of autonomy in enabling innovation to happen. The case studies show how midwife roles, as much as maternity services, are changing. Where midwives are given the time, resources and autonomy, they can be effective leaders and active participants in the improvement and redesign of maternity services.
Innovation and improvement in maternity services

Reductions in public sector spending, rising costs, demographic change, and increased public expectations are forcing public services to find new ways of working. If the increased spending on public services in the first decade of the 21st century was accompanied by a focus on improvement, then the second decade is increasingly focused on innovation.

In part this is a response to the changed spending environment; public service managers are finding that the efficiency savings demanded of them mean that they have to redesign services, build new partnerships, and engage the workforce in changing established ways of working. However, there are also longer-term challenges, such as the need to improve productivity in healthcare and to achieve better outcomes for chronic conditions. In our relatively centralised public health system, there is also a sense that frequent change and improvement initiatives have inhibited the appetite and capacity of organisations to deliver radical improvements. Building cultures and systems for innovation may offer a less reactive and more effective and sustainable way of improving what they do.

What is innovation?

Public service innovation is still a relatively new field of enquiry. The NHS Institute for Innovation and Improvement describes innovation as being ‘about doing things differently or doing different things to achieve large gains in performance.’ NESTA provides more detail stating that; ‘An innovation is the implementation of a new or significantly improved product (goods or service), or process, a new marketing method, or a new organisational method in business practices, workplace organisation or external relations’. They note, however, that in contrast to private sector innovation, public sector innovation must be assessed on a range of social as well as economic value indicators.

Innovation will not always mean immediate radical change. In the short-term, innovation might be incremental; for example, introducing new processes to an existing service. However, over the long-term, innovation might be the complete reconfiguration of the service.

The drivers of innovation in public services are also likely to be different to those in the private sector. Competition is less of an incentive to innovate than in the private sector, because direct competition with alternative providers is limited in many areas. However, customer or user feedback and transparency of performance can encourage innovation.

Drivers for innovation may include political pushes, the capacity and desires of the workforce, financial and non-financial support, technology, and the presence or involvement of third and private sector organisations. But the size and complexity of public sector organisations, entrenched belief systems and ways of working, risk aversion, professional resistance, change fatigue and a lack of time and funding can act as barriers.

Apart from needing reasons to innovate, studies also point to the wider context within which innovation takes place. The level of autonomy individuals and organisations have can affect their ability to develop and trial new ideas, and to implement change. Clearly the accountability and ownership structures of the public sector affect levels of autonomy. The public sector also has its own cultures and approach to leadership, which can be influential. It can affect the extent to which innovation is embedded within the day to day work of the organisation, as well as the types of collaboration and connections with other organisations that are likely to lead to further innovation.
Human capital is also a key factor in innovation, and the skills necessary for innovation, such as creativity, team working and cognitive skills, are becoming increasingly important. Although radical innovations often gain more attention, there is some evidence that the incremental innovations that use existing technologies and systems are overall more significant for the performance of any one economy. This type of continuous improvement can require different ways of working that engage the entire workforce and enable them to contribute to innovation. Work organisation that increases the autonomy, skills utilisation, involvement and participation of the workforce can support this.

**Innovation in the NHS**

Work is only just beginning to measure innovation capability and activity in the NHS, and its impact on performance, but the perception has always been that the structures and cultures of the NHS work to inhibit innovation. In fact, recent surveys purport to show that innovation activity is strengthening, but many NHS organisations are still far from achieving a systematic approach to innovation.

NHS organisations have gained more autonomy in recent years, particularly through the introduction of Foundation Trusts, but the NHS remains a fairly centralised system, with accountability to the centre, and the secretary of state able to exert considerable influence over policy and practice through targets and other measures. The status of the NHS in society, and the attachment to certain organisational forms such as hospitals, can also affect innovation. In a public health system incentives to take risks and innovate are not always clear; the penalties for failed innovation can be significant, and the rewards do not always accrue to those taking the risks.

However, innovation does take place in the NHS, and government policy has tried to make it more of a priority through, for example, the QIPP agenda. The NHS Institute finds that the innovation that takes place in the NHS is likely to be service or process innovation. The biggest impact of NHS innovation is thought to be efficiency, and in the current public spending climate, this continues to be a priority.

The wider structures and cultures of the NHS can encourage or inhibit innovation, but trusts can also affect innovation, particularly through the leadership and the structures and processes that are put in place to facilitate innovation. Barriers to innovation can also exist at the trust or service level.

For example, research finds that public sector innovation is often initiated by the people who work there; by frontline staff and middle managers. When senior managers or those in strategic roles are questioned, they report that frontline staff are indeed often the best source of ideas, but when staff are questioned about the whether the culture of their organisation supports innovation, results are markedly different. This raises questions about the extent to which organisations have in place the cultures and systems to enable innovation.

Other barriers, reinforced by the case studies in this report, is that staff often don’t believe that innovation is part of their day to day job; only 39 per cent of staff in NHS trusts thought innovation was a core part of their role. There is also some suggestion, both in the literature and in the case studies, that successive change initiatives can lead to change fatigue among the workforce and management, particularly if such initiatives are ‘owned’ and led from the top of the organisation.
Innovation and improvement in maternity services

Maternity care is set apart from other parts of the health service, in that most of the services maternity units provide are to healthy women undergoing a normal physiological process. Innovation, therefore, has not necessarily been focused on changing the normal birth pathway. Indeed, several of those interviewed for this study commented on the unchanged nature of the essential role of the midwife in supporting women in birth. The principle driver of innovation and improvement has been safety. The UK now has one of the lowest infant mortality rates in the world, at 4.8 per cent per 1000 live births in 2006, although the safety of women and babies during pregnancy and birth is still an area of concern. While childbirth is on the whole safe, when things go wrong the consequences can be grave. Clearly innovation in maternity services has to be carefully balanced with an assessment of the risks.

A more recent driver of change in maternity services has been the desire to increase choice for women through pregnancy, birth and in postnatal care. The introduction of a set of national guarantees has given women a choice, for example, over where they give birth and where they access antenatal care, with the emphasis on providing a service that is more tailored to the individual, and provides additional support to those with the greatest needs. The majority of women (92 per cent) will give birth in a consultant led unit, in a hospital.

Safety has often been the primary driver of innovation and improvement, but quality and value for money have also been important. There has been widespread support, for example, from professional bodies as well as government to increase the normal birth rate, in the belief that normal birth offers good outcomes for women and babies and it is also a more effective use of resources. As demonstrated in the case studies, there are signs that this has had led to changes in policy and practice.

Change has also been driven by the evolution of the midwife role in maternity services. The Next Stage Review of 2008 placed midwives at the heart of maternity care, and saw the development of their role as one of the greatest opportunities for improving quality and safety. The subsequent Commission on the Future of Nursing and Midwifery built on the NSR and set out some of the ambitions for the future midwife role. In the context of increasing clinical and social complexity and risk, midwives were seen as taking on a greater leadership role in the coordination and design of maternity services, and acting as the lead clinician throughout the maternity and newborn pathway.

There are also a number of more structural factors that affect innovation in maternity services. Innovation is also affected by the nature of the service and the relationships with the service users. Mental health services, for example, are believed to have higher rates of innovation. One of the reasons for this is the often long-term relationships with service users, and cultures that have encouraged user participation in service design and governance. Maternity, in contrast, has relatively short relationships with its service users, and although they may have regular contact with the service over a seven month period, once the baby is born, contact quickly ends. Feedback can therefore be quite static, and service user involvement more limited.

Maternity care in the UK has also developed and evolved over time in response to a number of changing demographic factors. Across the UK, maternity services have faced rising demand as the birth rate has increased. Rises in demand in many areas have outstripped increases in the size of the workforce,
particularly midwives, and trusts have had to increase productivity significantly to continue to provide a good level of service with fewer resources. The greater prevalence of births with complicating factors as a result of rises in the number of older mothers, multiple births, obesity and diabetes has also put pressure on resources. Greater complexity has also required more specialist skills from the maternity workforce.

About the report

There are constraints as well as drivers of innovation in maternity services, but innovation and improvement are happening, and will need to increase in the coming years. This research was conducted to find out what drives and enables innovation and improvement in maternity services. Where innovation is taking place, why has it happened, and what factors have enabled change? A better understanding of the factors influencing innovation and improvement, and particularly the conditions necessary to enable the workforce to participate in innovation, could help other services to find better ways of working.

The IPA, working with the RCM, identified a number of maternity services that have introduced new ways of working, new practices or processes, to improve performance. Some were in the early stages of implementation. Others had a longer history of implementing change, and as well as improving outcomes, were looking to find better and more sustainable ways of improving services.

Some of the changes that have been made in these services will be of interest to others looking for specific examples of how to improve performance. But the challenge for the NHS is to find ways of constantly improving the quality, safety and value for money of the services they provide. It is therefore equally important to understand the conditions that enable innovation and improvement to take place.

The financial pressures facing the NHS and the structural reorganisation associated with the Health and Social Care Act will affect the nature of innovation and improvement. Two of these case studies show the role that SHAs can play in driving innovation and providing the necessary information and resources. SHAs are to be abolished, but there may be important lessons that can be drawn for future regional networks. The impact of the reforms on the workforce and workforce morale are also critical. The case studies show the role midwives can play in designing and leading service improvement if they have the time, support and resources. However, the case studies also show pursuing value for money alone is rarely sufficient; midwives need confidence that change will lead to better services for women and midwives if they are to engage.

The impact of public sector innovation is often held back by ineffective knowledge networks, which prevent those from working in similar settings from learning from one another. As well as stimulating debate on what is necessary to support innovation in the NHS, it is hoped this report will also help to raise awareness of the innovation taking place in maternity services.
Case studies

The South Central Strategic Health Authority maternity network

The South Central Strategic Health Authority (SHA) covers Berkshire, Buckinghamshire, Hampshire, the Isle of Wight and Oxfordshire, with a combined population of 4 million. The SHA region has approximately 50,000 births per year, largely delivered at the region’s 11 hospitals.

Following the Darzi review (2008) South Central SHA established several programmes of work, one of which focused on the maternity and newborn clinical pathway. In keeping with the ambition to increase clinical leadership in the NHS, South Central SHA appointed a consultant midwife to work alongside the non-clinical programme director to lead the work in this area.

The challenge

The SHA has responsibility for monitoring and improving the quality and safety of services in the region, as well as ensuring value for money. As with all parts of the NHS, South Central SHA will have to make substantial financial savings. The SHA identified the need for £12 million of savings from the maternity budget over the next three years. The region has seen an increase in the birth rate in recent years, making further demands on limited resources.

At the same time, the SHA wanted to improve both commissioning, productivity, quality and safety whilst reducing unnecessary variation in maternity services across the region. Some working within maternity services in the region were concerned that the split between commissioners and providers had led to a weakening of the relationship between the two, which might be impacting on the quality of commissioning. Maternity services often forms a small part of the commissioners’ role, which may cover the whole of children’s services, and therefore commissioners had little opportunity to develop their expertise in this area. The data gathered by the SHA also revealed a certain amount of variation in the ways in which maternity services were delivered across the region, suggesting scope for an assessment of best practice.

The solution

The associate director of the maternity and newborn programme saw an opportunity to use the existing maternity network to address some of these issues. The network was seen as a suitable vehicle to review existing practice across the region, and by strengthening its activity, it could act as a more effective driver of performance improvement. The SHA was also identified as the only institution that could bring together commissioners and providers to discuss service improvement.

The maternity network originally held separate meetings for heads of midwifery, maternity commissioners and obstetricians. Although the heads of midwifery would still meet together, additional meetings were scheduled which included obstetricians and maternity commissioners.
To help build the relationships between the network members and also to begin joint work on reviewing the service across the region, the programme directors designed and commissioned a leadership development course from an external provider for the commissioners, obstetricians and heads of midwifery. The course, entitled Leading for Quality, was run over the course of the year and included six two day sessions. The course covered a range of areas, such as helping the participants to understand how they can influence those within their organisations and achieve change, and how they lead service improvement in a way that engaged the workforce. It also encouraged participants to work together to unpick what constituted good practice, and to think beyond current clinical guidelines to explore what users really wanted from the service and how commissioners, obstetricians and midwives could work together to achieve it. Customer service, for example, was seen as an important area for improvement, and so participants were introduced to leading private sector retailers to gain a different perspective on what customer service was and how to achieve it.

One outcome of the course was the development of the regional maternity service specification. The programme heads worked to adapt the national community services specification, and through the course consulted and involved the commissioners and providers discussing how it could be adopted across the region. Usually individual commissioners and providers would develop the service specification between them, but this approach enabled the commissioners and providers to draw on a greater level of expertise, and to agree the specification in the context of the shared goals established through the network. From the SHA’s position the shared maternity specification helped remove some variation in service provision across the region.

The course allowed participants to understand each other’s role better, and the constraints they faced. Although some trusts had good relationships with their commissioners, others had very little contact, and so the course helped them to build relationships. By building a shared understanding of excellent maternity services and the changes needed to achieve that level of performance, commissioners were able to explore critically the role of commissioning in achieving service improvement and build their confidence in challenging providers over service standards. Finally, the course strengthened the involvement and commitment of commissioners, obstetricians and heads of midwifery to the maternity network, and allowed it to go on to address a range of performance issues.

Simultaneously, the two heads of the network worked with commissioners and providers to support and help them in their day to day roles. The consultant midwife worked with providers and the associate director of the maternity and newborn programme largely worked with the commissioners. One commissioner described the associate director role in empowering her to work more effectively with her local providers by bolstering her technical knowledge, facilitating the relationship with the local provider and offering personal support. The associate director also carried out a series of one-to-one meetings with commissioners before the leadership course began to assess the extent of their knowledge of maternity services and what support they required.

One of the areas the maternity network has worked together on is increasing the number of normal births by standardising the normal birth pathway. There was already commitment from the members of the network to increasing normal births for clinical reasons, but the requirement for maternity services to find productivity savings sharpened the focus. In the Buckinghamshire area, for example, the birth rate
had risen 8 per cent in 2010/11, and 45 per cent of women giving birth were over 35 years of age. These factors increased pressure on resources and the age profile of women giving birth made caesarean sections and other forms of intervention more likely, requiring even more effort on the part of providers and commissioners if normal birth targets were to be met. The network was helpful because it enabled different maternity services to review the evidence on what worked by comparing practice against one another. The SHA had the expert knowledge and the evidence to show what constituted as best practice, and was also able to present the evidence on the costs of different inputs, and the overall costs to each trust of their current practice. For example, if all trusts were able to lower their caesarean section rate to 20 per cent, the savings across the region were estimated to be £4.8 million.

The associate director also initiated a programme of work through the network to look at unscheduled antenatal activity across the region. Unscheduled antenatal activity was identified as a significant cost to trusts, and also the way trusts managed these cases varied. In this case, unscheduled antenatal activity was not necessarily identified by individual trusts and commissioners as an issue, but the SHA working with the network built consensus around the goal of standardising practice.

The SHA's aim was to encourage trusts to review why they did what they did, and the costs and outcomes of these practices. For example, reviewing the admissions criteria and what role GPs and community midwives can play in reducing unscheduled attendance at maternity units. Through gathering data the SHA was able to benchmark activity and develop a minimum set of operational standards. Using this information as the starting point, the SHA encouraged the members of the network to identify best practice and to find more innovative ways of working in their own organisation. In response to this programme of work, several providers have employed triage midwives, who run a telephone service for women to call and get advice about which service it is appropriate to use, rather than walking in to the maternity unit. Online information was also improved across the region.

Enablers of innovation and improvement

Maternity networks that bring together heads of midwifery are not uncommon, but the way that the maternity network was developed at South Central SHA, as well as its role in driving service improvement across the region is significant.

The SHA invested considerable resources in the maternity network by recruiting a clinical and non-clinical director to lead the maternity and newborn programme. The appointments created capacity to coordinate the work of the network and also the expertise and information necessary to enable service improvement. The fact that one of the programme directors was also a consultant midwife was seen as important in encouraging engagement in the network from providers and reassuring members that the leadership had the expertise and insight to set realistic goals. The associate director also had considerable expertise in commissioning and maternity services, and was therefore able to firstly identify the potential for improved commissioning in addressing some of the challenges facing the region, and she also provided the commissioners with expert support.

A particularly important part of the support the programme directors provided, in terms of enabling innovation, was the wide range of knowledge and information they could draw on to inform the network members. Maternity often constituted only one aspect of the commissioners’ roles, and they described
the time constraints they faced and how that limited their ability to access information on new developments and best practice. The maternity network helped to compensate for this by having dedicated resource and expertise in the form of the programme leaders who were able to find, select and disseminate the information the network needed to participate in service improvement.

All those interviewed for this study identified the leadership of the maternity network as the principle factor in enabling the network to succeed. The directors were able to drive the work forward, provide the network with the information necessary, support the relationship between individual providers and commissioners, and sustain the engagement of the individual network members. Their personal leadership capabilities were regarded as important in sustaining the engagement of the network members, and resolving problems when they arose.

It may also be significant that the network was run from the SHA. The programme leaders could engage network members in the work because many of them stood to gain from the additional support and resources available, particularly commissioners of maternity services. But the SHA also has some status as a statutory body with responsibility for performance management, which may have encouraged engagement from providers and commissioners. Bringing together providers and commissioners was the key to many of the innovations that took place, and it was acknowledged that there were no other institutions apart from the SHA that had relationships with both parties and would be able to draw them together.

The network itself has built relationships between providers and commissioners that have helped them to work more effectively together, and to develop innovative solutions at the local level to the challenges, such as increasing normal births, that were identified through the network. One commissioner described how in her area the relationship between the PCT and the provider had all but broken down, but through the network it had been rebuilt and now worked effectively. At a broader level, relationships have been built between different commissioners, heads of midwifery and obstetricians, which has helped the spread of information and sharing of best practice to continue. Network members have appreciated the opportunity to discuss problems and develop solutions with all the key actors present, making implementation more likely. Since the end of the leadership course, joint meetings have continued in response to the demand from network members.

Leaders of maternity services often comment on maternity’s relatively low profile within large hospital trusts. And yet as one head of midwifery commented, the profile of the service and the support of the trust’s senior leadership is an important factor in driving innovation and service improvement and enabling the implementation of new ideas. Network members - heads of midwifery and commissioners - felt that their involvement in the maternity network and the innovative work it was undertaking helped raise their profile within their organisations and the profile of the service. In a semi-competitive healthcare environment, senior leaders were also interested in the information network members had on the practice and performance of other providers and PCTs.

Finally, the maternity network was provided with sufficient resources to support its work. The SHA funded the programme lead posts, but it also gave the programme leads the resources to commission activities such as the Leading for Quality programme.
Barriers

The effectiveness of the network depends to a great extent on the participation of the network members. Time constraints arising from the pressures of their day to day role were identified by members of the network as a factor limiting the impact of the network. The Leading for Quality course consisted of six two day sessions over twelve months, and regular joint meetings continue to take place. In order to keep network members engaged and committed to implementing change, members believed there needed to be a certain amount of momentum, which was conditional on regular participation.

The commissioners and providers from one area within the SHA region did not participate in the maternity network at all, limiting the influence of the programme. Several participants noted that the obstetricians from some areas were less committed to the network than the other professional groups. Where this was the case, commissioners and heads of midwifery had found it harder to implement changes that were likely to increase normal births and reduce caesarean sections.

Part of the reason why regular participation is important in networks is because the efficacy of the network is dependent on the relationships between members; and members need to spend time together in order to build those relationships. However, the changeover of personnel, which has been accelerated as a result of the current NHS reorganisation, has also affected the strength of relationships within the network.

Finally, network members could face constraints within their own organisations which limited their ability to implement change. Although they personally were committed to the network’s objectives, either a lack of awareness of the network’s programme, or a different set of priorities within the PCT or trust could affect the network members’ ability to implement change. For example, a trust in one area decided to reduce the number of midwives it employed, which affected the approach the head of midwifery and maternity commissioner had been developing.

Lessons learned

- Networks – Networks can be a powerful tool for building the relationships necessary to deliver change. They can also become a forum for sharing information and problem solving, and an effective means of performance improvement.
- Resources – Networks that are well resourced, both financially and with expert knowledge, are able to sustain the engagement of network members, and deliver greater value
- Leadership – Leadership is vital in making sure that networks deliver tangible outcomes for performance improvement
- Information – Commissioners and providers can find it difficult to access information necessary for performance improvement and innovation, either because of time constraints or knowledge of where to find information. Networks and SHAs can play an important role in identifying, selecting and distributing relevant information.
Productive Maternity at Nottingham

Background

Nottingham University Hospitals Trust is a large hospital trust spread over two main sites. The maternity service encompasses two consultant led units, a stand alongside midwife led unit, and the community midwifery service for the area.

The trust delivers approximately 10,500 babies per year and employs 350 whole time equivalent (WTE) midwives and 74 maternity support workers.

The challenge

NUH had been formed through the merger of two smaller trusts Nottingham City Hospital and Queens Medical Centre in 2006. Since then, there had been a series of change initiatives, focusing on financial reform, infection control and service quality. In common with the rest of the NHS, NUH faced a period of reduced public spending increases, and was looking to develop a more strategic approach to improving value for money while improving the quality of services provided. In 2010 they launched their Better for You programme, a set of tools and techniques designed to encourage and enable sustainable service improvement with the involvement of employees and patients.

The maternity service has undergone changes in recent years, partly as a result of the merger, but also through their involvement in the Productive Ward scheme that NUH had been participating in. However, patient experience data, employee feedback and CQC reports highlighted the need for further improvements. Changes in staffing levels had made some ways of working unsustainable, and it was recognised that midwives and MSWs needed to be working at their appropriate skills level in order to improve productivity. Targets such as one on one care in labour had focused attention on intrapartum care, but as the head of midwifery pointed out, there was a need to look at the maternity service as a whole, to review practice and procedures and identify improvements that would benefit women and staff and improve value for money. There was also recognition from longer standing members of staff that although technology had changed, the processes used to organise the service had changed very little, and that there were better ways of working.

Both the trust and the maternity service were looking as much for a sustainable approach to change and greater innovation capacity as a specific set of outcomes. Previous schemes, including Productive Ward, were seen as having engaged too few people to bring about a change in culture, or to bring about change beyond the specific area in which the programme was implemented. Other change initiatives were seen as too top down and lacking evaluation, so negative impacts on patients and staff were not taken sufficiently into account.

The solution

In 2010 the trust’s Better for You team and the maternity service senior management decided to establish a maternity Better for You project. Productive Maternity was launched in January 2011 and a project lead post was created to coordinate the work. Two midwives, one from each of the trust’s sites,
took on the role as a job share. Funding for the project was found from within the maternity budget, but the trust provided resources in the form of training and advisers to support the project. The project has a steering group made up of senior managers and clinical leads. The steering group feeds in to the Project Management Office, which coordinates Better for You projects across the trust.

**The objectives of the project are as follows:**

- To have staff who are proud of where they work, what they do and how they do it
- To have clear processes which will enable staff to deliver consistent care with excellence
- To have a service which responds to feedback from women, staff and other service-users
- To have a culture of continuous assessment and improvement

Productive Maternity is due to run for 18 months, by which time the project aims to have built enough knowledge and awareness of the tools and techniques among the workforce to make changes sustainable, and create the knowledge and capacity among the workforce to make innovation and continuous improvement embedded in the service. As the project leads acknowledge, the aim of this project is not just to undertake a one off reorganisation, but to alter staff attitudes and behaviours so that they believe that participating in and sometimes leading change is part of everyone’s job, and feel empowered to make changes to improve the service no matter how big or small the change. Involving people in the Better for You projects is seen as an important step in changing attitudes; the idea is that being part of a positive change programme will help alter expectations of what is possible, give people the skills and confidence to make continuous improvements in their day to day work and take ownership of the change.

The project focuses on three areas of the maternity service; antenatal, in patient, and intrapartum care. The project leads led a process mapping exercise to understand how the services currently worked, and also mapped the patient journey. These events were facilitated by the project leads with support from the Project Management Office, and all staff working in that area, including those attached to different departments, were invited to participate in the exercise. The project leads were aware of the need to engage as many staff as possible, and so a lot of work was put into communicating with staff to let them know about the events and how they could get involved. In recognition of the difficulty of engaging all staff, particularly in areas where there is little spare capacity, additional meetings were set up and notice boards used to display process maps and gather additional feedback.

The first area for review was the antenatal clinic. By following and recording a patient’s journey through the clinic, staff had identified a number of areas for improvement to reduce the distances travelled, reduce waiting time and create a calmer, more ordered atmosphere. Staff were also keen to separate out functions within the clinic area so that women receiving care from the foetal medicine team were not using the same areas as women attending the clinic for scheduled checkups.

The project leads organised an initial day’s trial, altering the layout of the antenatal clinic, appointing a band 7 midwife to act as a clinic coordinator, and changing the signage, entrances and exits. The new layout gained positive feedback from women visiting the clinic, who noticed the calmer atmosphere and more coordinated system, and from women visiting the foetal medicine unit, who appreciated being
separate from those attending the clinic for more routine appointments. A longer trial was scheduled, to be evaluated using feedback from staff and women, and monitoring waiting times and the patient journey. The steering group will then use the evaluation to decide whether the changes should be implemented on a permanent basis.

The project leads reported improvements in morale and the sense of ownership among the antenatal clinic staff as a result of being given the opportunity to be meaningfully involved in change in the clinic and improve its operation. Despite considerable effort, some staff have remained reluctant to engage, either through lack of time, cynicism, or a belief that there was no need for change. However, for others, confidence that the project was able to deliver change increased their engagement in it.

Sub-projects are now being established in the post-natal and intrapartum parts of the service to begin the redesign and trial phases of the work. A number of staff from these parts of the service have attended the Better for You training to develop their skills and enable them to help lead the work.

Enabling factors for innovation and change

Productive Maternity is not yet complete, and so the full impact of the project as well as its sustainability cannot be fully assessed. However, the project is already well established and a number of activities have taken place across the maternity unit. Even at this stage it is possible to identify factors that have enabled innovations to take place, and change to be implemented.

The Better for You programme has developed a set of tools and techniques, broadly based on lean principles, to create a uniform approach to problem solving and change management. The tools enable non-experts to lead projects by giving them a clear system to follow, but more importantly, they are designed to engage the wider workforce through the whole process, from identifying problems to suggesting, trialling and evaluating solutions. As one of the project leads said, “This is what’s different to other change we’ve done, which has said ‘this is the problem’. We’ve said, ‘we think this might be the problem, but let’s all dig a bit deeper.’” Projects are not given set outcomes or targets to achieve, and the objectives are not necessarily shaped by clinical guidelines, so by engaging in the process staff are able to influence both what is improved and how that improvement is achieved.

The impact of any change on staff is given weight in the evaluation process as well as the impact on service users and value for money measures. The close engagement of the workforce not only lessens resistance to the changes that arise from the project, but staff are also able to identify early on many of the practical problems with implementation.

It may also be significant that the project is led by two midwives, rather than non-clinical or senior clinical managers. The project leads did have to acquire the necessary skills and training to manage the project which possibly slowed the project down. However, they believed that the staff were more willing to engage in the project because they knew that the project leads understood ‘how things really were’ for staff, shared their values, and were less likely to implement unnecessary change.

The fact that one of the project leads worked in the antenatal clinic where the first redesign and trial took place was particularly helpful. As she was aware of the frustrations of the staff with the current way of working and already knew many of the staff, she was able to use these two elements to engage people
in the change programme. The other project lead is the staff side representative for the Royal College of Midwives; the involvement of the trade union in the programme may also have helped reassure staff and encouraged them to take part.

Productive Maternity was not given a specific set of targets for saving money or achieving clinical outcomes, but the project relies heavily on data to identify appropriate innovations and understand their impact on staff, women and resources. The relevant data are identified and gathered, analysed and used by the project team, giving them both access and control of the information. Although the appropriate data can be a powerful enabler of change, the Better for You Programme Director at the trust believes that changing attitudes towards data has been important too. The NHS staff are often presented with data to demonstrate underperformance, which can be de-motivating. In order to achieve effective change staff needed to get used to seeing data as an improvement tool.

As part of a wider change programme, those working on the Productive Maternity project have benefitted from access to training and skills development. The two project leads received training in project management from the NHS Institute for Improvement and Innovation, but the trust also offers training on each of the Better for You modules (set up and plan, discovery, design and trial, implement, embed) through the academy. This training is open to all, and those who have been interested in Productive Maternity, or are taking on leadership roles, have been encouraged to attend.

The trust has also offered expertise and resources to support the project. The PMO as the central coordinating body is able to gather lessons from each project and share that knowledge with others to improve the process. Advisers from the trust’s management or PMO are able to pass on knowledge and transfer skills to project leads, helping to build capacity. The trust also did a lot of work to communicate with staff about the Better for You programme when it launched, which has helped change programmes launched under the Better for You banner gain acceptance more quickly and given projects greater legitimacy.

Productive Maternity has a steering group made up of clinical leads and senior managers from the family health directorate. As well as being able to advise the project leads, this group is made up of people of sufficient seniority to take decisions regarding the project’s development. Although they feed into the PMO, and ultimately the trust board, having a steering group with sufficiently senior personnel has provided the project leads with the necessary support to overcome obstacles.

**Barriers to innovation**

Productive Ward came about through an analysis of the limitations of previous change initiatives. All those interviewed for this study identified the lack of engagement and involvement of the staff, both in identifying problems as well as solutions, as a factor in the failure, or at least the limited success of previous initiatives.

Better for You is designed to overcome many of these problems by making change a bottom up process, but the engagement and involvement of people remains one of the biggest barriers to change taking place. Despite considerable efforts on the part of the project leads there were still some who would not engage in the antenatal clinic redesign. This could have been as a result of the pressure of clinical work,
reluctance to change ways of working, or residual cynicism among the staff resulting from previous failed change programmes. In the labour suites, the project leads had found it more difficult to involve staff in the process mapping exercise; the pace and intensity of work in that part of the service made it difficult for staff to find the time to take part. The process mapping and analysis could in theory take place with relatively little involvement from the wider staff, and changes could be trialled and implemented. But the project team were aware that the ultimate objective of the project was to bring about a change in attitudes and behaviour and establish a culture of continuous improvement, and for this to take place, as many people needed to be involved in the change process as possible therefore further dates were set.

Productive Maternity is an 18 month project, and there are questions about the ability of such ‘project’ based initiatives to effect sustainable change. Although it might bring about a series of improvements, continuous improvement is only likely to develop if it becomes integrated into staffs’ day to day roles. However, in the short-term a project based approach has had some positive impacts. Many of the staff in the antenatal clinic were aware that there were problems in current ways of working, and that things could work better. Without the project, staff felt that there was no infrastructure or clear process to support change, and that a lack of change over a period of time had lowered staff expectations that things could change. There was also a sense that given that change had typically been designed and led from the top in the past, that it was not the responsibility of other staff. To address this perception the trust had launched a ‘Just do it’ award scheme designed to encourage employees to make small changes.

The antenatal clinic largely deals with scheduled work, and therefore a reorganisation could take place in a planned and ordered fashion. It was apparent from other Better for You projects that had taken place in the trust, that the challenge of meeting targets, responding to inspections, or changing practice to meet clinical guidelines, could put pressure on holistic change programmes like Better for You. In these circumstances, it has taken a significant amount of support and drive on the part of the project leaders and the PMO to keep staff engaged in the Better for You programme, which is designed to deliver long term change, if it was not seen as relevant to the more immediate problems.

Lessons learned

- Infrastructure and processes – The Better for You programme provided a clear set of processes through which innovation and improvement could take place and be managed. The high visibility of the programme and the structured involvement opportunities provided channels through which staff ideas could be fed in, and were part of the work to build an innovation and improvement infrastructure. However, a lack of staff time could limit their involvement.
- Skills and training – project leads and other staff were given training in the skills needed to manage projects and the specific Better for You improvement tools and techniques.
- Support – senior managers with decision-making ability sat on a project board to offer advice and remove obstacles to change. The trust also developed its own in-house improvement and innovation experts through the Project Management Office, who were able to offer expert support, advice and information.
- Clinical leadership – the maternity project is led by two midwives. This has been important in encouraging staff participation, particularly midwives, and building trust and confidence in the project.
Maternity Support Worker Apprenticeships at Basildon

Background

Basildon and Thurrock University Hospitals NHS Foundation Trust maternity unit is a medium sized unit delivering between 4,100 and 4,300 babies per year. Based at Basildon hospital, it is comprised of a midwife led unit and a high risk delivery unit. The maternity unit also manages the community midwifery service.

The maternity service has 146 whole time equivalent (WTE) midwives of which 123 WTE are clinical midwives. There are 36 WTE maternity support workers (MSWs).

The challenge

In 2009 the Strategic Health Authority (SHA) conducted a cross regional skills mix review, and then brought the heads of midwifery from the region’s 17 maternity units together to discuss the workforce challenges facing the region, in the context of improving quality, safety, and productivity. The review also included analysis of the MSW role in maternity care could be developed to allow a better use of midwife skills. The SHA wanted to achieve the midwife to birth ratio of 1 midwife for every 30 births. To achieve this ratio it was estimated that there would need to be a further 600 midwives across the region. The SHA also set a target for maternity units to achieve a 90/10 ratio in the maternity workforce, between midwives and support workers.

Basildon was typical of many trusts in facing the challenge of managing workforce costs while meeting national staffing targets. In 2004 Basildon maternity unit carried out a workforce analysis using the Birthrate Plus tool, on the basis of 4,000 births per year. It found that they were under established by 50 WTE midwives if they were to achieve the ratio of 1:28 midwives to deliveries (the ratio set at that particular time).

Over the next five years more midwives were gradually recruited at Basildon, with some additional funding from the PCT when Maternity Matters was introduced, and some from the trust. By 2009 Basildon had achieved a ratio of 1:32.

The solution

Support staff have been a feature of maternity services for some time. Nurse auxiliaries, nursery nurses, clinical support workers and more recently MSWs have taken on a range of tasks, typically in the community and postnatal wards.

Basildon maternity unit had already been developing the MSW role, following a consultation with midwives on what could be done to free up their time to focus on core tasks. The role and responsibilities of the MSW were developed, and they took on a number of postnatal tasks, including weighing babies and carrying out Guthrie tests and supporting women with feeding, bathing and other aspects of newborn care, and on the postnatal wards carrying out tasks such as post operative observations. Midwives remain professionally responsible and accountable for any task carried out on their behalf.
Following the SHA’s skills mix review, fully trained MSWs were identified as a way in which maternity units might improve quality and safety in the short-term, and help address longer term productivity concerns. Once qualified, MSWs can make up 10 per cent of the midwife numbers in the midwife to birth ratio, but they also enable maternity units to focus their midwife resources on those areas where midwife expertise is critical, such as caring for women in labour. In 2009 the SHA offered all maternity units across the region the funding to develop a bespoke maternity support worker apprenticeship course, with up to 15 places for each unit. The head of midwifery at Basildon, took up the opportunity, and worked with the trust’s Staff Training and Development manager, a former midwife, to design the course.

From the head of midwifery’s perspective, the MSW apprenticeship offered a new route into midwifery, helping to solve some of the medium-term workforce supply problems. It also gave the maternity unit the chance to play a much bigger role in shaping the training and development of future midwives and it offered a progression route for MSWs, helping to improve retention and engagement. In the wider context, factors such as demographic change, rising obesity and associated diseases, drug and alcohol use and child protection policies have made the delivery of maternity services more complex. Developing the knowledge of MSWs so that they have greater understanding of these issues, and also the reasoning behind the tasks they carry out, was seen as making it more likely that they would be able to contribute to the task of identifying potential problems.

The first intake of maternity support worker apprentices began the two year course in November 2010, with 10 students, dropping to 7 at the end of the first year. All the candidates were already employed as MSWs at the trust. The SHA, through the county level workforce group, provided funding for the course, while the maternity unit funded the salaries of the MSWs, including release time for two days per month to attend training.

The advanced apprenticeship is divided into three modules, and is accredited by City & Guilds:

1. Key skills: level two literacy and numeracy
2. Technical certificate: level three with modules covering communication; health and safety; wellbeing, protection, privacy and dignity; personal development; quality of service delivery; and service improvement
3. NVQ Health level three: 10 units, some focusing specifically on maternity

For the second intake, this has been replaced by the new level three diploma in maternity and paediatric support.

The MSW apprenticeship was designed by the trust’s Staff Training and Development Team in conjunction with their education partner, Anglia Ruskin University. Together they developed the curriculum and employed a course supervisor to deliver the modules. City and Guilds prescribes the competencies for the apprenticeship. The first year is largely class room based, and focuses largely on the technical certificate and the core units of the NVQ. Apprentices complete the technical certificate in the second year, and also complete the maternity units of the NVQ with input from the maternity unit. Midwives act as Mentors to assess apprentices’ practical skills, but case studies and reflective writing are also used in assessment.
The apprentices cited the opportunity for personal development and better pay as two of the main reasons for enrolling on the course. The MSWs so far are not carrying out any new tasks in their day to day work, but several said that the course had provided them with a better understanding of the work they do. However, the final job description for MSWs that had completed apprenticeships, their pay band and the recognition of the qualification for entry to midwifery training had not been confirmed yet, so apprentices were unsure of the final value of the apprenticeship.

In 2011 the SHA confirmed funding to run the course again for a further 15 apprentices.

**Innovation enablers**

The use of MSWs has provoked some debate within the midwifery profession, and concerns have been expressed about the risk of MSWs replacing midwives. However, rising birth rates, restricted public spending and targets such as those to increase women’s choice and improve one to one care in labour have meant that maternity services have had to innovate to improve productivity and meet changing user needs.

MSWs had been used for some time at Basildon maternity unit, and their role had gradually been expanded following the Birthrate Plus analysis carried out in 2004. Although there was some initial hesitation from midwives to delegate certain tasks to MSWs, by 2009 their expanded role had gained acceptance among the wider workforce.

The SHA has a role in leading workforce planning for the region, and through its maternity network, was able to act as a coordinator and bring together heads of midwifery to discuss the challenges for the midwifery workforce. As well as acting as the initiator for the MSW apprenticeship, the SHA was also able to provide funding to enable the scheme to take place.

The head of midwifery at Basildon had a personal commitment to developing the workforce which encouraged her to take up the apprenticeship offer from the SHA. She had, over a long period of time at Basildon, seen the benefits of developing and providing opportunities for the workforce. She was also interested in finding new routes into midwifery that gave those with strong soft skills but fewer academic qualifications, the opportunity to enter the profession.

The high level of autonomy the head of midwifery has over workforce issues meant that she was able to implement the MSW apprenticeship quickly, and could avoid having to go through many bureaucratic processes. Other parts of the trust were developing their own apprenticeships and so the environment was generally supportive of this sort of initiative.

The trust has its own staff education and training facilities, and established partnerships with local education providers. The trust therefore had sufficient resources and relationships in place to design and deliver most of the training in-house. The course supervisor had delivered training to MSWs at a different trust, so had sufficient experience to design the curriculum and training programme.
The training of MSWs also draws on midwives’ time, as they are required to act as mentors in the second year of the course. Midwives are already required to supervise and mentor student midwives, and so there were some concerns that this would be seen as an additional burden. However, it was agreed that midwives would be able to use time spent supervising MSWs to contribute to the overall hours they are required to spend on mentoring.

Barriers

Funding for the first MSW apprenticeship course was provided by the SHA, and a further amount has been agreed by the SHA to run the course again. Now that the development route has been established, the head of midwifery would be reluctant to remove it. However, the SHA has made no guarantees about long term funding of the course, and there is currently no scope within the maternity budget to cover the course. Without the support of the SHA, the course would close if an alternative source of funding could not be found.

Other resource constraints limiting the continuation or expansion of the apprenticeship are the finite resources of the staff development and training department and the costs associated with releasing MSWs for training.

The recruitment of further MSW apprentices will, in part, depend on the extent to which apprenticeships are seen as an opportunity for progression. At the moment it is unclear exactly how the job description and banding of MSWs who have completed an apprenticeship will differ from those who have not. Although the head of midwifery is aware of the issue, MSW apprenticeships are a new development in the NHS, and so there are no standardised job descriptions to draw on.

Lessons learned

- Regional leadership – The SHA played a key role in identifying the opportunity for MSWs to play an important role in meeting the workforce challenges, and working with trusts to develop a new MSW apprenticeship. The SHA used the maternity network to engage heads of midwifery in the delivery of MSW apprenticeships.
- Autonomy – The autonomy of the maternity unity and the head of midwifery on workforce matters meant that Basildon maternity unit could act quickly to take up the opportunity of funding for MSW apprenticeships, and could work with the SHA and the in-house training service to develop the apprenticeship.
- Workforce support – Basildon had initially gained support for expanding MSW roles by consulting midwives on what resources the management could provide to help them to release time to care. Increasing MSW responsibilities helped midwives to focus on core tasks. This has helped the service to continue to develop the role.
Modernising maternity at East Cheshire NHS trust

The maternity service in East Cheshire covers a large geographical area, but contains only one consultant led maternity unit based in Macclesfield. The service as a whole delivers approximately 2000 babies per year. The majority of midwives are team midwives, working in eight teams.

The challenge

Until 2003 the midwives at East Cheshire NHS trust were divided into community midwives and hospital midwives, effectively functioning as separate services, but managed by one head of midwifery. Typically, as midwives became more experienced, they moved into roles in the community, leading to a concentration of experienced midwives in that part of the service.

In 2003, the service was reorganised into eight teams, which would cover hospital and community and primary care, thereby creating an integrated midwifery service. This brought more flexibility to draw resources to where they were needed on a day to day basis, it spread the workforce expertise more evenly across the service, and it broadened the skills of the team midwives. As well as moving around to respond to day to day changes in demand, team midwives are scheduled to cover community, hospital and on-call functions. There is a small core staff on the labour ward and a core night staff.

The team structure created more flexibility for the service to respond to demand, but it also created variation across the service as teams developed their own ways of working. The variation not only meant that women were receiving different care across the region, but it suggested that there were opportunities to identify best practice, to reduce costs and to release time.

The solution

In 2009 three new team leader posts were created, and a recruitment exercise carried out to appoint people to the newly designed roles. Each team leader oversees up to three teams, with a band 6 deputy team leader in place in each team to oversee its day to day running. These new roles were intended to create more capacity to lead service improvement, and to increase coordination between the teams.

The new team leaders worked closely together and were able to see the differences in practice between their teams. Information given to women, the number of post-natal visits, where midwives delivered care, the organisation of clinics and parent education all varied across the service. The lack of central coordination before the team leaders were appointed also meant that the information was not always shared across the service, and so midwives were not always aware of changes taking place.

Building on the 2003 reforms, the service wanted to continue to improve efficiency and flexibility to allow resources to be directed to the areas where they were needed most. The changing public spending environment, although it had not directly impacted on maternity services at the time, did focus attention on the need to continue to improve efficiency and value for money.
Team leaders identified areas where practice varied, and led projects to review and improve ways of working. One of the first areas for review was the post-natal pathway. One Team leader was aware that different teams and different midwives had developed their own approaches to post-natal care. Women were receiving varying numbers of post-natal check-up appointments, some in the home and some in clinics, and for varying lengths of time. The aim was to refocus the resources to where they were most needed and to reform the way post-natal care was delivered so that it was more convenient for women.

The team leaders used NICE guidelines as a starting point along with the patient feedback gathered through evaluation forms. By standardising the number of post-natal appointments for women who were well supported and coping well, the service could increase the support to those who needed more support. Rather than taking place in the home, appointments were offered at clinics in children’s centres with fixed appointment times. This meant women did not have to wait at home, and by holding clinics in children’s centres, women were more likely to connect with other services. The clinics meant that appointment times were standardised, and that midwives were no longer travelling between appointments, increasing the number of women they were able to see in one day.

The impact of the changes has been increased satisfaction, as shown in the patient feedback, greater productivity and reduced travelling time and costs. The reorganisation has also meant that the service has been able to redeploy midwives to other areas. The service now achieves one to one care in labour rates of 97 per cent.

Using a similar process, another team leader led a review and redesign of parent education. Parent education had mostly been delivered in the evenings by a midwife who was scheduled on one of the wards. This meant that attendees could receive sessions from different midwives, which occasionally led to inconsistencies. It also drew midwives off the labour or post-natal ward, affecting staffing levels. Again, using the feedback gathered from evaluation forms, the team leader redesigned the parent education programme in conjunction with team midwives. A dedicated parent education midwife was appointed to deliver most of the parent education. A parent education programme has also been introduced to the post-natal ward to help with the transition to parenthood.

The changes in parent education have increased the quality and consistency of education, and protected staffing resources in other areas. The service has also seen a decrease in the length of stay for women, and increased breast feeding initiation rates.

**Innovation enablers**

Change has become almost a constant at the East Cheshire maternity service. The reorganisation in 2003 not only led to the integration of the midwifery service, but it also brought a lot more variety into the day to day change work of team midwives. Further changes took place between 2003 and 2009, including moving more of the postnatal and ante-natal services into children’s centres to strengthen connections between the maternity service and other children’s and family services. The team leaders agreed that by the time of the 2009 changes, and the subsequent redesigns of various parts of the service, midwives had become very used to change, which has helped the team leaders engage the workforce in the service improvement initiatives.
The new team leader roles have also been important in enabling innovation by creating capacity to lead and manage change. The new team leader roles did not increase overall management time among the midwives, but it did distribute it more evenly, so that those with management roles were close to service delivery and therefore able to identify areas for improvement. In contrast to the previous team leader roles which were largely awarded on seniority, the new team leaders were recruited in part for their interest in service improvement and leadership abilities.

As the team leaders have become more experienced, they have gained more confidence and autonomy, and they have been encouraged by the head of midwifery to pursue ideas and projects for service improvement. The team leaders have had to present business plans to the head of midwifery before projects have taken place, but their independence has allowed them to implement change relatively quickly.

The team leaders divide their time between clinical and management duties, meaning that, as one team leader described it, ‘they have a foot in both camps’. The team leaders believe that this has been important in building trust among the workforce and that even though they are managers, they know what challenges team midwives are facing, and that the proposed changes are for the improvement of the service for both women and midwives.

To help make the case for change and to demonstrate the value of the changes that have been made, the team leaders have used patient feedback data. The feedback gathered from women using the service highlighted, for example, the frustrations of waiting for a midwife to visit for a postnatal check up at home. After moving to fixed time appointment at the children’s centres, the feedback validated the case for change and allayed fears expressed by midwives about possible negative consequences.

Perhaps as a result of ‘having a foot in both camps’, the team leaders have chosen to share as much information as possible with the workforce and to adopt a consultative approach. Team meetings now take place in all teams on a regular basis which encourages information sharing. They believe that this reflects their personal leadership style and that it is a useful tool in promoting engagement in service improvement. Feedback from the workforce has enabled the team leaders to refine their changes to services, and the consultative approach has meant that some of the changes that have taken place, such as employing a number of core staff on the postnatal ward, have arisen as a result of workforce suggestions.

**Innovation barriers**

The capacity created by the new team leader roles is limited, and time is seen as one of the biggest barriers to innovation. Although the team leaders have allocated management time, the unpredictable demands of a busy maternity unit can mean that other pressures can encroach on that time. The team leaders had a number of new projects they wanted to launch and improvements they wanted to make, but found that time was a limiting factor. They wanted to do more work to improve communications with the GPs, for example, to raise the profile of the maternity service and to improve the flow of information between GPs and midwives, but had struggled to find the time.
The maternity service can identify savings from the changes that have taken place over the last two years. But the midwives were aware that the need to find savings across the NHS could affect the progress that has been made. Management time has been seen as particularly vulnerable in cost savings exercises because it is an upfront investment, although the team leaders believed that by creating management capacity in the right places, savings had been made elsewhere.

**Lessons learned**

- **Leadership** - Creating leadership capacity at the right level, and with the mandate to improve services and lead change is important. Appointing leaders who are also practitioners can be helpful in engaging and gaining the support of the workforce.
- **Patient feedback** – Patient feedback can be a powerful tool in service redesign. It can help leaders to build the case for change, and also allay concerns as changes are implemented.
- **Change** – Well managed change can help build support and momentum for further change. Continuous improvement requires the workforce to expect that change is likely to be a constant, but that they will be able to influence and shape the changes that are made.
Conclusions

The case studies echo the national picture; maternity units are reshaping their services to cope with rising demand and restricted resources. Innovation and improvement are essential in meeting efficiency savings targets, but it is clear that those leading change are looking to innovate in order to improve quality, safety and value for money. Changes were frequently evaluated against these three criteria; it was not an either/or situation.

In several of these cases the changes are more accurately described as improvement or incremental innovation. But in pursuing improvement, leaders were trying to build long lasting capacity, cultures and structures for innovation. Previous approaches to improvement had often been top down and focused on achieving a particular objective, be it cost savings or reduced hospital infection rates. The unforeseen consequences of implementing change in this way have included staff disengagement and reduced commitment to implementation, both of which have had short-term impacts on performance and longer-term impacts on the attitudes of staff to change.

The attitudes and expectations of frontline staff is still one of the biggest barriers to change. In some units change had become a constant, and midwives had come to accept this. But their involvement and support was conditional on the belief that change was in the interests of women and also made it easier for midwives to do their job well. Even in these units, good communication and giving midwives the opportunity to feedback and influence change was essential. In other units, midwives often knew how performance could be improved, or where things could be better, and had ideas for new processes or practices. However, a lack of empowerment, belief that things can change, sometimes the absence of structures and processes to enable midwives to offer feedback or make changes, held them back. Helping frontline staff to see innovation and improvement as a core part of their role, and giving them the tools to make change, will be important in increasing innovation intensity.

In most of these case studies, clinical leadership has had an important role to play in enabling innovation and improvement to take place. The task of leading innovation and improvement has not always been given to the most senior member of staff; in several of the studies leadership has been delegated to senior practitioners. Improvements that are designed and led by midwives can have several advantages; there is more confidence among staff that their welfare will be taken into account, staff are more likely to trust that changes are well thought through and able to be implemented, and staff may find it easier to offer feedback when those leading change are accessible to them. There are challenges too though; in many areas of their work midwives function as part of a multidisciplinary team, and achieving change requires the buy-in of all those actors, which can be difficult. Midwives do not necessarily have the skills to lead innovation and improvement, and so it can be necessary to invest in leadership and management skills.

Building relationships between different professional groups is a reoccurring theme in the studies. Improving relationships between commissioners and providers, between midwives, obstetricians, managers and health visitors, are important in enabling innovation. In part this is a pragmatic response to modern maternity services, where no one professional group working alone is able to improve performance. But it is also necessary in a large health system, where professionals working in different
organisations are likely to be facing similar challenges. By creating well resourced networks which connect people together, new practice and knowledge can be readily shared, speeding up the innovation process and widening its impact. Networks here can be a means of collaboration and a source of competition; sharing performance data is an effective way of improving practice.

Several of the studies show the importance of autonomy in enabling innovation to happen. Because of the unique type of services they offer, maternity units often operate with a greater degree of independence than other functions within a trust. This can bring benefits; some heads of midwifery felt able to act quickly and implement new ideas with few bureaucratic obstacles. However, midwifery leaders also acknowledged that the involvement and support of a trusts’ senior leadership were crucial in driving improvement over the long-term, particularly where that change involved a number of different departments or groups of professionals. Midwifery leaders needed to get the balance right.

These case studies show how midwife roles, as much as maternity services, are changing. The pressure to increase productivity, as well as safety and quality, means that maternity services have to make sure they deploy midwife skills to where they are needed most. This has caused concern for midwives and their representatives, who see the potential for such changes to threaten quality and safety, and alter the opportunities for midwives to progress in the workplace. Others, however, see the development of the maternity support worker role as a new route into midwifery, and an important part of the effort to increase midwife numbers.

Where midwives are given the time, resources and autonomy, they can be effective leaders and active participants in the improvement and redesign of maternity services. Increasing innovation and improvement in the NHS in the challenging years ahead will depend on politicians, policymakers as well as public sector leaders looking to see how their actions inhibit or enable innovation.